Esej/Essay

pp. 91–115

Reconsidering the Distinction between Western and Post-socialist Biological Citizenship: Reflections on Developments in Reproductive Medicine in Serbia

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Abstract: *This paper analyzes the distinction between Western and post-socialist biological citizenship, formulated by Rose and Novas in terms of "active" versus "passive" biological citizenship projects, in order to propose a refinement of the conceptualization of biological citizenship as a global assemblage. In a global assemblage, global and local elements interact and global forms get transformed in ways that are not reducible to preconceived notions and internal social dynamics. However, Rose and Novas draw a clear-cut distinction between Western and post-socialist biological citizenship that can preclude the investigation of their global and assembled character. Discussion in this paper of recent developments in reproductive biological citizenship in post-socialist Serbia serves to demonstrate the insufficiency of a dichotomous conceptualization of biological citizenship. Civic initiative that challenges the medical management of childbirth, online support groups of women undergoing in-vitro fertilization, and the online reporting of corruption in reproductive medical services are analyzed. Through citizens' online communication, specific transformations of global forms are examined in interaction with other elements of the Serbian post-socialist context, and in the relations between citizens, the state and reproductive medicine. The paper suggests that the deconstruction of dichotomous notions, together with ethnographic research of emergent forms of biological citizenship, promises further improvements in comparative conceptual frameworks in medical anthropology.*

Keywords: *western and post-socialist biological citizenship, biosocialities, reproductive medicine, post-socialism*

Introduction

Anthropology approaches citizenship not only as political status, as a matter of belonging in a political community, with attendant rights and obligations, but as a practice and process interwoven with many areas of social life.[1] The concept of

1 I am grateful to reviewers for their helpful suggestions for improving this paper.

biological citizenship draws attention to various practices in which conceptions about biological existence, health and illness interact with political membership and classifications. It is increasingly used in anthropological research, along with similar concepts such as therapeutical citizenship, genetic citizenship, and biosocialities (Casper and Currah 2011; Gibbon and Novas 2008). Enumerating and sorting out phenomena encompassed by the concept of biological citizenship is a work in progress. This concept is still being filled with content, as new developments emerge in the context of global transformations, post-socialist transitions, and biotechnological developments. However, for engaging in research of biologically based socialities today, together with new empirical work we need "a broader range of concepts and more refinement in the ones we already have in our inventory" (Rabinow 2008: 192). As Rabinow (2008) and Whyte (2009) both state, new conceptual distinctions are likely to emerge through ethnographic work, undertaken together with reflexive and critical conceptual work. Since medical anthropology in post-socialist countries is an emerging field of research, its results are expected to have more to contribute to the comparative theorization of biological citizenship. In this paper, I engage in reflection on developments in post-socialist Serbia, as well as in conceptual clarifications aiming to contribute to a refinement of conceptualizations of biological citizenship.

In the contemporary globalized world, projects of biological citizenship are situated at intersections of the global and local, and it is important to understand what they have in common with developments elsewhere, and how they unfold under different constellations of political, economic, and cultural conditions. Post-socialist societies provide a promising field for comparative research of forms of biological citizenship. Post-socialist reforms in different societies do not seem to follow any unified and predetermined path (see: Buyandelgeriyn 2008), and they continue to present us with uncertain and unexpected outcomes. This demands new conceptualizations, which should be able to account for changing and complex interrelations of phenomena that owe their existence to multiple determinations, such as: internal social dynamics, historical and cultural legacies, citizens' demands, international pressures, awareness about Western developments, and globally influential dynamics and forms. Post-socialist projects of biological citizenship emerge under the global influence of neoliberalism, information technology, and biotechnology which enter into "global assemblages" (Collier and Ong 2005), interacting with local conditions.

Recent reproductive biological citizenship projects in Serbia that are broadly outlined in this paper provide reflections to address the insufficiency of dichotomous conceptualizations of biological citizenship. I discuss emerging developments and conditions of biological citizenship in Serbia: civic activism demanding changes in the medical management of childbirth in Serbia, in-vitro fertilization online support groups, and the online reporting of corruptive behaviours in medi-

cal institutions. I focus mainly on data from the online communication of Serbian citizens who are involved in constructing these biological citizenship projects and debating their conditions. Initiative demanding changes in the medical management of childbirth, as an example of identity politics, and online support groups for women undergoing IVF, as a form of biosociality, are discussed in order to provide reflections on the insufficiency of the distinction that Nikolas Rose and Carlos Novas (2005) draw between Western and post-socialist biological citizenship. I analyze how these forms of socialities are assembled in the interaction of global and local elements, in order to suggest that a conceptualization of biological citizenship as a global assemblage allows for a more useful approach to its different territorializations.

Biological citizenship as a global assemblage

Foucault has shown that, since the 18th and over the course of the 19th century, the historical relationship between sovereign power and the populations and individuals it governs has shifted towards biopower, which is exercised by taking hold over life and which regulates its subjects through their biological properties – insofar as they are living beings (Foucault 2003: 239). Within this shift, biomedicine has gained importance and authority in governing populations, defined through their vital characteristics, upon which the state could intervene. Extending on Foucault's theory of biopower, new conceptualizations have been formulated in recent years, concerning the emerging relationships between the state and citizens' biology. Paul Rabinow (1992) proposed the term "biosocialities" originally in 1992, in relation to new knowledge of the human genome and new biotechnological procedures, to point to the "formation of new group and individual identities and practices arising out of these new truths" (Rabinow 1996: 102). More recently, Adriana Petryna (2002) has formulated an ethnographically based account of biopower and biological citizenship in post-socialist Ukraine. Rose and Novas write in the often cited formulation that I focus on in this paper that they use the term biological citizenship "descriptively, to encompass all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species" (Rose and Novas 2005: 440). Their conceptualization of biological citizenship is meant to serve as a general framework for analyzing how "specific biological presuppositions [have] shaped conceptions of what it means to be a citizen, and underpinned distinctions between actual, potential, troublesome, and impossible citizens" (Rose and Novas 2005: 440).

There are two directions in which biological citizens are constituted, according to Rose and Novas. The direction from above refers to the ways the state authorities and medical services frame their understanding of "what it means to be a cit-

izen" (Rose and Novas 2005: 440), and act upon citizens according to biologically based distinctions. The direction from below refers to the ways in which citizens associate with fellow citizens, and distinguish "themselves from others, noncitizens, partly in biological terms" (Rose and Novas 2005: 441). Associating from below makes it possible to formulate demands directed to state authorities, whether for "particular protections, for the enactment or cessation of particular policies or actions, or [for] access to special resources" (Rose and Novas 2005: 441). It also brings into existence plural perspectives on biology that can challenge medical doctrines. Citizenship projects from below encompass not only what Rabinow calls biosociality, but also health identity politics in which citizens can claim rights, rather than being "mere beneficiaries, clients, or customers" (Whyte 2009: 9).

In many citizenship projects, biosocial subjectivity and identity politics are interrelated. Subjectivities and identities based on biology can be variously positioned in relation to state-supported and medical discourses, and they variously interact with existing identity categories. Within the biopower approach, "the workings of discourse and technology in the shaping of subjectivity and new kinds of social relations" (Whyte 2009: 9) are problematized. As Whyte explains, the analysis of subjectivities is concerned with people's conceptions of self in relation to medical diagnoses, health conditions, and biotechnological procedures. Identity, on the other hand, is about "similarity and difference between selves and others" (Whyte 2009: 7). Identity politics revaluates these differences in a struggle for recognition and rights. However, there can be a close relation between biosocial subjectivities and identity politics, "an overlap between movements making claims for justice from the larger society and support groups for people sharing a common problem" (Whyte 2009: 8). Identity politics, moreover, needs "to alter both the self-concepts and societal conceptions of their participants" (Anspach 1979, cited in Whyte 2009: 7).

Rose and Novas write that, like other dimensions of citizenship, biological citizenship is mutating within the dynamics of globalization: it gets de-territorialized, while at the same time it is "undergoing transformation and re-territorializing itself along national, local, and transnational dimensions" (Rose and Novas 2005: 440). The concept of "global assemblage" provides a useful way of thinking about different territorializations of biological citizenship in which anthropological problems are articulated and phenomena are re/formed. It is elaborated by Collier and Ong (2005) in their text in the collection they edited, in which Rose and Novas' article is also published. Although Rose and Novas' statements about mutations and about the de- and re-territorialisation of biological citizenship reveal that they conceptualize it as a global assemblage, they then go on to draw a clear-cut distinction between Western and post-socialist biological citizenship projects which undermines the possibility of the analysis of the global and assembled character of these projects. I want to suggest that the framework of global as-

semblages allows for a more useful conceptualization of different territorializations of biological citizenship.

Collier and Ong use the concept of assemblage, originating in the work of Deleuze and Guattari (1987), to point to the way in which anthropological problems and phenomena can be conceptualized today as unities of elements that are "heterogeneous, contingent, unstable, partial, and situated" (Collier and Ong 2005: 12). Their temporality is emergent and they are products of multiple determinations (Collier and Ong 2005: 12). What gives them global quality is that they are not reducible to internal social or cultural determinations, and their origin and significance are global. This is what they owe to "global forms" (Collier and Ong 2005: 11), which are capable to move between contexts, due to their capacity to be decontextualized and recontextualized. Drawing on Giddens and Weber, Collier and Ong write:

> "Global forms are able to assimilate themselves to new environments, to code heterogeneous contexts and objects in terms that are amenable to control and valuation. At the same time, the conditions of possibility of this movement are complex. Global forms are limited or delimited by specific technical infrastructures, administrative apparatuses, or value regimes, not by the vagaries of a social or cultural field" (Collier and Ong 2005: 11).

The authors point to the following examples of global forms: neoliberalism, as "a pervasive form of political rationality whose formal and 'global' character allows it to enter into novel relationships with diverse value orientations and political positions" (Collier and Ong 2005: 17); technoscience, "whether material technology or specialized social expertise" (Collier and Ong 2005: 11); and "forms of politics and ethics structured around collectivities to the extent that they are not defined culturally (...) or socially..." (Collier and Ong 2005: 11). In the last sense, the editors consider biological citizenship as conceptualized by Rose and Novas to be "global".

Global assemblage is a composite concept which suggests, according to Collier and Ong, "inherent tensions: global implies broadly encompassing, seamless, and mobile; assemblage implies heterogeneous, contingent, unstable, partial, and situated" (Collier and Ong 2005: 12). However, global elements are not left untransformed when they enter into assemblages of biological citizenship, when they are territorialized within a specific constellation of conditions and as they interact with other elements of these conditions. Although biological citizenship is a widely encompassing and global notion for Rose and Novas, drawing a clear-cut distinction between the West and post-socialism eventually confines their interpretation of forms of biological citizenship to preconceived internal social and cultural dynamics and determinations, in which the role of the global, as well as the specific interactions of elements in its assemblages, remains unclear. This dichotomous

conceptualization does not provide an adequate framework for an understanding of the specificities of emergent forms of biological citizenship (such as the ones I discuss in this paper), and of the role of global forms (such as neoliberalism and biotechnologies) in its dynamic and complex mutations. In drawing clear-cut distinctions, there is a certain risk that notions of "Western" and "non-Western" could become dichotomized and internally homogenized, and figured as the main determinants of current varieties of biological citizenship, instead of being examined in terms of their emergence and construction by biological citizens and social scientists.

Western and post-socialist biological citizenship

The distinction between Western and post-socialist developments is made by Rose and Novas (Rose and Novas 2005) in terms of "active" versus "passive" biological citizenship projects, assembling two sets of characteristic elements and conditions. The authors focus primarily on documenting current and emerging forms of biological citizenship in the West, and on its biosocialities, which are exemplified in patient support groups and characterized as active. They use Adriana Petryna's (2002) ethnographic account of biological citizenship in post-socialist Ukraine as an example of a passive variety of biological citizenship and contrast it to what they consider characteristically Western developments.

Rose and Novas recognize a normative element in the Western variety of biological citizenship which presupposes a self-managing and prudent personhood that conforms to a norm of individual "activism and responsibility" (Rose and Novas 2005: 451) in relation to one's health and biological make-up. What the term "active" in their conception primarily refers to is a specific relationship of citizens to themselves. Although the term "neoliberal" is not mentioned in their article, the kind of active citizens' relationship with medicine and with themselves that the authors see as characteristic of Western developments can be better understood by turning to two of Rose's other works that deal with neoliberal subjectivity (Rose 1996) and with mutations in the pastoral power of medical and other experts (Rose 2007).

Rose relies on Foucault, who examined how neoliberals in the 20th century have modelled "the overall exercise of political power ... on the principles of a market economy" (Foucault 2008: 131), and extended economic analysis to the "interpretation of a whole domain previously thought to be non-economic" (Foucault 2008: 219). Within neoliberal governmentality, there is no longer a relationship of individuals and communities to the state and society as a whole which would be unmediated by the market. Neoliberalism relies on a new version of *homo oeconomicus*, who is conceived as "an entrepreneur of himself" (Foucault 2008: 226). In Rose's analysis of neoliberal governmentality, subjects are conceived "as individu-

als who are to be active in their own government" (Rose 1996: 330). In contrast to the social government of welfare states, "advanced liberal" (Rose 1996: 335) societies govern their citizens through "the activation of individual commitments, energies and choices, through personal morality within a community setting" (Rose 1996: 335).

Rose writes that welfare states were criticized because of the powers and "the discretionary scope that [they] accorded to professionals and bureaucrats" (Rose 1996: 330). In his book on new biological subjectivities (Rose 2007), he analyzes the mutations of the pastoral power of medical and other experts in governing contemporary biological citizens. The pastoral power of medical experts to guide and counsel citizens in managing their health no longer functions by making decisions in the name of citizens, it is not administered by the state and it is no longer concerned "with the flock as a whole" (Rose 2007: 73). It is becoming a plural, contested, and relational field, in which a variety of agencies (medical experts, bioethicists, biotechnological and pharmacological companies, scientists and citizen initiatives) offer guidance according to which citizens can manage themselves as somatic and genetic individuals. This type of relationship with medical authority is described by Rose and Novas as different from that of the past, when medicine encouraged "passive and compliant patienthood" (Rose and Novas 2005: 448). Citizens are now expected to be active participants in their recovery and to make choices in the management of their biology.

Neoliberal subjects who are governed through their self-government and community, and who actively negotiate the recommendations of medical and other experts, correspond precisely to active biological citizens in Western biosocialities described by Rose and Novas. When taking individual responsibility for one's health becomes a norm, those who fail to be responsible become "new types of problematic persons" (Rose and Novas 2005: 451). Active biological citizens are required to gain expertise about their somatic conditions and their genetic susceptibilities independently of medical authority, but not necessarily in opposition to it. Nevertheless, individuals may still be required to manage their health risks in compliance with medical doctrines in order to be regarded as fully unproblematic (see: Petersen 1996).

Rose and Novas contrast their description of biological citizenship in the West to Petryna's (2002) account of post-socialist biological citizenship:

> "Biological citizenship in the Ukraine is not a matter of contesting the power of medical expertise, nor of sculpting an autonomous life in which collectively shaped self-understandings are a pathway to self-fulfilment: it takes the form of demanding redress from the state for certain ills, in the form of benefits, and activism is oriented toward demanding medical recognition for a condition and obtaining expert judgment as a credential to obtain state benefit" (Rose and Novas 2005: 451).

In the excerpt below, the authors draw a more general distinction between Western and post-socialist biological citizenship:

> "In Western nations – Europe, Australia and the United States – this is not taking the form of fatalism and passivity, and nor are we seeing a revival of genetic or biological determinism. Whilst in the residual social states in the post-Soviet era, biological citizenship may focus on the demand for financial support from state authorities, in the West novel practices of biological choice are taking place within a "regime of the self" as a prudent yet enterprising individual, actively shaping his or her life course through acts of choice" (Rose and Novas 2005: 458).

In these passages, demanding benefits from the state in the context of state and medical paternalism is seen as the most central characteristic of passive biological citizenship. In contrast, obtaining state benefits is not a central concern for active biological citizens who relate to the state as entrepreneurial individuals. Petryna's analysis of biological citizenship in post-socialist Ukraine, used to exemplify passive biological citizenship, however, is far more nuanced than this interpretation suggests. Petryna writes that the Ukranian state "perpetuates its paternalistic role as the giver and taker of social resources and as life insurer" (Petryna, 2002: 118) by extending disability status and state benefits to a great number of citizens after the Chernobyl catastrophe. The state proposed, in cooperation with medical experts and scientists, definitions of symptoms of radiation-caused diseases which could qualify citizens for benefits. Nevertheless, the activity of citizens from below was present in Ukraine. Although she reports that Ukrainians interpreted their inability to work and their adoption of the sick role as "passivity", Petryna does not use the term "passive" to describe the behaviour and attitudes of citizens who strived to be assigned disability status. She describes how Ukrainians negotiated their health conditions with doctors, engaged in networking and information-sharing and acquired expertise about symptoms and medical conditions that would assure them state benefits. They were "working the system", and finding corruptive ways to obtain diagnoses and state benefits. She also writes about the activity of non-governmental organizations which advocated the rights of disability status claimers and assisted them in navigating the system, and about some instances of entrepreneurship.

Petryna is aware that the overall economic climate and neoliberal policies, resulting in a stark decline in employment opportunities and in the simultaneous dismantling of social services, form the context in which the Ukranian state perpetuates its paternalistic role. This is both a legacy from socialist times, and a result of governmental attempts to gain democratic legitimacy and provide some social security for its citizens in the aftermath of the Chernobyl nuclear disaster. The Ukrainian state has resorted to paternalistic measures in relation to large

parts of the population that were provided benefits, made under the claim of biological suffering. When considering post-socialist paternalism, the specific range of choices that are available to citizens should be taken into account. Insofar as the range of choices is limited, the market relations that neoliberal subjectivity relies on seem to be absent. However, the overall economic conditions in post-socialism result in increased social insecurity; they individualize responsibility and make inclusion in society uncertain. Biological citizens in Ukraine negotiated their social inclusion predominantly in terms of state-defined patienthood. Still, there was a space of individual initiative that mediated access to paternalistic forms of social security and that was not regulated according to formal rules, but rather relied on individual social skills and corruptive ties.

Anthropological research has shown how the "market economy in non-Western contexts operates much more on the basis of the rules of local cultures, kinship, and community rather than the rules in force in Western contexts" (Buyandelgeriyn 2008: 245). This is not to suggest that post-socialist societies are simply defined by their lack of formal organization and by social traditions that limit their progression towards Western models. Rather, there is no ideal form of market relations which is not mediated by, and formed in interaction with, local conditions, histories, and modes of government: thus its specific forms should be investigated empirically. Neoliberal governmentality interacts with other elements in assemblages of biological citizenship in post-socialist contexts, as well as in the West. In post-socialism, it can be recognized in the individualization of responsibility for managing citizens' biological existence, insofar as individuals are expected to rely on their own resources (including social connections) in gaining access to forms of social security. The individualization of responsibility poses a problem of unequal resources for both Western and post-socialist neoliberal subjects. Rose acknowledges that there is a difference between "the affiliated and the marginalized" (Rose 1996: 340) in neoliberal societies, where the affiliated are those who are "considered 'included': the individuals and families who have the financial, educational and moral means to 'pass' in their role as active citizens in responsible communities" (Rose 1996: 340). Neoliberal reforms result in the withdrawal of social responsibility for citizens' health and while paternalistic measures seek to reduce insecurity, they also themselves produce new form of inequality between those who manage to be included, and who gain access to social resources, and those who do not.

Rose and Novas do not engage with mutations of neoliberal governmentality, or with the role of other global elements (such as communication technologies and biotechnologies) in assemblages of post-socialist biological citizenship. Their clear-cut distinction between Western and post-socialist biological citizenship does not indicate how exchange and mutual influences might be possible between them, and how the global character of biological citizenship might be conceived. According to them, active biological citizenship emerges as a result

of several developments: the Western history "of medical activism by those who refuse the status of mere 'patients'" (Rose and Novas 2005: 442); specifically Western "conceptions of citizenship and personhood" (Rose and Novas 2005: 451); and the availability of communication on the Internet (which is not itself a crucial factor). They write that forms of biosociality, exemplified by patient support groups in the West, still have "no visible presence in whole geographic regions" (Rose and Novas 2005: 451), but it is unclear if they consider that similar forms of biological citizenship could emerge in regions where these developments were absent and to what extent communication on the Internet could contribute to the emergence of new forms of biosocialities in non-Western contexts. They rightly point to the global reach of the human rights discourses of international organizations for health promotion which can be used in identity politics in non-Western contexts. We should also consider the global presence, through international health promotion, of norms of personhood which demand taking active responsibility for one's health and which might be used to render problematic those who lack the material and cultural resources to act responsibly (see: Macleod 2009; Elbe 2005). I will refer to these globally present forms and discourses in the following discussion of Serbian developments.

Developments in Serbian reproductive biological citizenship

Recent developments in reproductive biological citizenship in post-socialist Serbia emerge in the complex and dynamic environment of turbulent and uncertain post-socialist times. I argue that it is not possible to interpret them as an example of what Rose and Novas characterize as post-socialist, passive, biological citizenship. I do not wish to suggest that in Serbia we are witnessing an evolution towards what these authors describe as Western, active, biological citizenship either. What is interpreted as the Western or post-socialist character of assemblages of biological citizenship projects does not pre-exist their emergence and construction. Instead of framing these developments in dichotomous terms, we should closely examine their global and assembled character, and the specific ways in which citizenship mutates and global forms get transformed.

I will first examine two biological citizenship projects: civic activism demanding changes in the medical management of childbirth in Serbia and in-vitro fertilization support groups. The discourses of women demanding changes in the medical management of childbirth and women undergoing in-vitro fertilization demonstrate different ways in which identity and sociality are formed around shared biological conditions of reproduction. I will also discuss online reports of corruption in reproductive medical services in order to point to the social conditions of reproductive medicine and to the citizens' subjectivities formed in Serbia in the relations between reproduction, medicine and the state.

Access to the Internet is considered by Rose and Novas as an enabling factor for active biological citizenship. Their focus on the activity of online patient support groups, exemplifying today's Western biosocialities, is criticized because it makes the discussion of biological citizenship "programmatic and decontextualized" (Whyte 2009: 11) and ignores social differences between people and their lifeworlds. Rose and Novas recognize that there are inequalities in Internet access. At the same time, they assume that the ability to share stories and communicate about one's biological conditions is a defining feature of active biological citizenship, which makes it attainable only to those who have access to communication, together with media and scientific literacy. Both identity politics and biosocialities depend on subjects who engage in public story-telling and public debates around biological conditions. Human rights discourses, mentioned by Rose and Novas, and norms of personhood originating in Western developments that have gained global influence, can also contribute to the proliferation of stories about biological conditions in non-Western contexts.

Although developments in Serbian reproductive biological citizenship are not confined to their presence on the Internet, online communication plays a crucial role in their emergence and facilitates public story-telling around reproduction. Internet communication is widely, although unevenly, adopted in Serbia, mostly by a relatively educated and affluent urban population. I base my discussion on Internet sources and online discourses with awareness that they only partially represent citizen's experiences in Serbia. Nevertheless, online communication in which community-making is visible provides an opportunity to investigate collectively created discourses. It is an important source of information for medical anthropology, since health information and advice proliferate on the Internet, where citizens share their stories about health and illness and form networks (Hardey, 2002). Access to other sources of information about medicine is limited in Serbia, both for citizens and social scientists. Knowledge about treatment options and actual medical practice is traditionally considered as an object of institutional discretion, reflecting the professional power and lack of accountability of medical doctors. Furthermore, due to increasing number of public accusations for medical mistreatment and for widespread corruption, doctors have become suspicious toward social scientists who wish to conduct observation in state-owned reproductive medical services.

Complaints about medical mistreatment, as well as reports about widespread corruption, are present on an almost daily basis in Serbian media. Citizens discuss their experiences regarding medical mistreatment and corruption on the Internet. In the context of corrupt and inefficient medical services, and the state's reluctance to implement ethical regulations and reforms in reproductive medicine, protection from medical mistreatment is not guaranteed and the legal prosecution of doctors is rarely achieved in Serbia. Citizens address their demands for regulation

and reform of medical services to government officials, due to continuing domination of state ownership of medical services. In their online communication citizens may rely on conceptions of self and discourses which originated in the West and have become globally influential, however, I consider that they use and transform them to construct stories according to their specific positioning in relation to medicine and the state in Serbian context.

A civic initiative for changing medical management of childbirth

"Mother Courage" is a civic initiative of women that challenges medical management of childbirth in Serbian state hospitals. It is an example of identity politics in which women demand rights and recognition from society. Rose and Novas write about a Western tradition of health identity politics as a precondition for active biological citizenship. I consider this example of identity politics in Serbia not as a repetition or imitation of Western developments, but as a project that is assembled by a number of conditions, and specifically positioned in relation to global and local discourses.

This civic initiative first emerged on the Internet in the fall of 2008. It started when one blogger, Ms. Stamenkovic, who later lead the initiative, published her story about giving birth to her son in a state-owned maternity hospital in the capital of Serbia in 2002. Following her invitation, other women began to contribute stories about their own experiences of giving birth, and consequently a civic initiative was formed that is still active today. The demands of the initiative were formulated at the beginning by Ms. Stamenkovic, who addressed them to Serbian Minister of health, and they included: the eradication of corruption in maternity services; an improvement in the communication of doctors and nurses with women who give birth; and changing what she saw as inefficient and harmful medical procedures in childbirth.

Women were invited to contribute their stories to a separate web-site established for the initiative and within months several hundred stories had been received and published anonymously.[2] The stories of women from Serbia were predominantly about the horrible situations and inhumane treatment they had experienced in hospitals, while Serbian women who live abroad told about their satisfaction with giving birth in "developed" countries. Women's stories served to provide evidence of the problems summarized in the demands of the initiative, to

2 The web-site of the initiative can still be found at its original address: http://www.majkahrabrost.com/. At the moment, it does not contain the materials (demands, women's stories, news and links to videos of TV media debates) that I used in my initial research of the online activity of the initiative. The current media activity of "Mother Courage" has moved to online social networks, and to the production of a series of six episodes, featuring women who talk about their experiences in childbirth, which was aired on television during 2012.

share information about conditions and medical practice in state hospitals, and as a platform for constructing a shared identity of women based on the experience of giving birth in state-owned maternity wards. However, this initiative remained widely inclusive, and was able to form alliances with other organizations of civic society, organizations of parents, other patient initiatives, some state officials, and with doctors who support reform of the medical management of childbirth and who organize against corruption.

Public narratives about giving birth have never before proliferated in Serbian media. "Mother Courage relies on women's stories of their experience as evidence of medical mistreatment and as an authorization of women's demands. Making women's experiences public resists a cultural script in which women are advised "to forget" (Kline 2010: 129) the experience of childbirth (presumably because it is traumatic) and which precludes identity politics. The use of women's stories can be seen as a global technique for identity construction and making claims for recognition and rights, originating in Western developments and embedding the notion of citizenship as a practice of making previously private experiences public. However, Serbian women's public sharing of stories emerged in a specific context, as a practice that could enable them to make demands, and not as a mere aspiration to conform to Western notions of citizenship.

Awareness of standard practices in Western countries has played a role in women's dissatisfaction with treatment in Serbia, which has not improved since socialist times. When the "Mother Courage" web-site was started, it stated on its home page that what motivates the publishing of women's stories is that they are strikingly similar to the "horror" stories that some women tell about their experiences of childbirth in Serbia from thirty years ago. However, while the initiative uses references to Western practices and international standards, it constructs them according to its own vision about desirable course of reforms in the country. In the first story, Ms. Stamenkovic made explicit that her expectations and hopes when she supported the civic movement for democratic government in the 1990s were that reforms, imagined after Western models, would be implemented after the change of political government in 2000. Such a framing of their demands reveals that women gathered around civic initiative see themselves as a part of a larger project of modernization in Serbia. The prospect that future democratic government would establish human rights standards and transparent medical procedures was a part of the social changes envisioned by citizens in civic protests against political government in the 1990s.

Women active in the civic initiative demonstrated that they possess expertise, not only about different models of childbirth management and medical procedures, but also about international human rights standards in health care. Ms. Stamenkovic questioned official state reports about maternal mortality in comparison with international figures and methods for record-keeping; she advocated

lowering the rates of episiotomies in comparison to rates in Sicilian maternity wards; and she advocated the presence of fathers during childbirth, based on its documented benefits for the progression of labor, and refuted doctors' claim that banning fathers from childbirth serves to avoid infections. She was knowledgeable and rational in TV debates with doctors and state officials, who made fewer references to statistical data and established medical knowledge. Nevertheless, doctors addressed women from the initiative primarily as noncompliant patients, and did not acknowledge their arguments for their scientific value.[3] They dismissed women's claims as untrustworthy, incompetent, or unrealistic. When women referred to Western or international standards, doctors responded that such standards are not applicable in Serbia, because it could not afford to implement them or because they would not be culturally appropriate. They portrayed women making such demands as agents of Western propaganda (similarly to democratic opposition supporters during the 1990s), or as indoctrinated fans of Hollywood movies, suggesting that references to Western standards of care indicate that women do not formulate their own legitimate demands and that they question legitimacy of childbirth management for the purpose of destabilizing an area of national interest.

"Mother Courage" did not demand the de-medicalization of childbirth. Following Riessman's model of medicalization (Riessman, 1998), we can say that the initiative does not deny that childbirth requires medical assistance; it only contests current medical procedures, the attitude of doctors, and the organization of medical practice. There is a parallel between the demands of the initiative and Western developments in the medical management of childbirth. As Chalmers writes, practices of medical management of childbirth in Eastern Europe at the end of the 1990s were "reminiscent of those prevalent in North America and Europe" (Chalmers 1997: 277) in the 1960s. They were characterized by medical preference for technological intervention, the application of inductions, routine episiotomies, the supine position, and the use of forceps. This description corresponds to practices that Serbian women reported and opposed. Chalmers believes that, under the influence of doctrines promoted by the World Health Organization and UNICEF, the Western "woman-centered and baby-friendly low-technology approach for the majority of women in childbirth" (Chalmers 1997: 273) would eventually prevail in Eastern Europe. This statement assumes that there is a developmental lag in post-socialist countries and that the course of their development is predictable.

3 The concept of authoritative knowledge about childbirth, elaborated by Brigitte Jordan (Jordan, 1997), is helpful in understanding doctors' lack of reliance on scientific evidence. She claims that "[t]he power of authoritative knowledge is not that it is correct but that it counts" (Jordan 1997: 58). Medical discourses thus do not have to refer to scientific knowledge to be authoritative, if they can rely on "cultural authority, economic power, and political influence" (Jordan 1997: 57).

Instead of adopting such a deterministic framework, we could consider that the global influence of human rights discourses of international health organizations, together with the conditions and discourses existing in Serbia, contributed to the formulation of the demands of Serbian women for reforms. In making their demands, the women also rely on the government's proclaimed goal to implement reforms according to the standards of the European Union, and on the identity of active citizens, formed through participation in civic protests during the 1990s.

"Mother Courage" addressed its demands for the regulation and reform of medical services to state officials. At the same time, it redefined women's relationship with the state via a pro-natalist discourse. The worries of the state over declining national birth rates, labelled the "white plague" (Shiffman, Skrabalo and Subotic, 2002), are often represented in catastrophic predictions of the total extinction of the nation.[4] The "white plague" rhetoric and pro-natalist discourse entail a responsibilization of women as reproducers of the nation (see: Yuval-Davis 1997). By stating in its motto that the Serbian nation should indeed "die" from a "white plague" if it allows the mistreating of women in childbirth, "Mother Courage" redefined women's relationship with the state. Declaring that women's right for self-determination is more important than their obligation to the nation to bear children, it made a demand that the state take responsibility for regulation and implement reforms in line with its own declarative concerns for the growth of the Serbian population.

State authorities initially reacted to the activity and publicity of "Mother Courage" as to a possible threat to their democratic legitimacy. Until the spring of 2009, they engaged in several tripartite debates with the initiator of "Mother Courage" and with medical doctors in television programs dealing with health issues. Although the women's initiative aimed to cooperate with doctors and state officials, the alliance between the Ministry of Health and the medical profession, which is claimed to be the main factor stopping reforms of childbirth management (Wagner 1997), seems to had eventually led to marginalization of women's demands.

Online support groups of women who undergo in-vitro fertilization

Another new development in reproductive biological citizenship in Serbia in recent years is the emergence of online support groups of women who undergo in-vitro fertilization treatment. Since 2006, when the Serbian government made

4 A member of Serbian Academy of Sciences, a body with an influential voice in Serbian politics, says, for example: "We are stricken by the white plague, there is less and less of us. (…) This is our deathly hour, and if we do not snap out of it (…) in a century we will not exist. That is the thought that torments me" (Marković 2006). Politicians, governmental health institutions and citizens reproduce such rhetoric, expressing worries that Serbs might become extinct, or become a minority in "their own" country, by being outnumbered by more fertile ethnicities.

a decision to cover the costs of IVF for a certain number of couples, information about basic facts about IVF, diagnostic tests, and procedures for applying for the state funds started to proliferate in online media, and lately active online communities of women became visible. These communities can be found on privately-owned or public Internet forums, dedicated to discussing parenthood, lifestyle, or health issues. In these communities, women share primarily practical information regarding all aspects of treatment, about maintaining health, dietary supplements, individual practices and routines. The users on a forum I observed know each others' reproductive histories and regularly exchange emotional support.[5] Communication revolves around IVF schedules, planning and progression toward the goal of achieving pregnancy. Criticism of the procedure is virtually non-existent, while claims about dissatisfaction with doctor's management of treatment are rare.

Through communication in online support groups, women undergoing IVF treatments in Serbia form biosociality around the technological procedure of assisted reproduction, which they hope will remedy their infertility, and they form their subjectivity based on the medically defined condition of infertility and in relation to state benefits. At the same time, they actively manage their treatment, gather knowledge they can apply in their self-management, and share information in order to achieve their reproductive goals. They use communication as a resource to inform themselves about infertility options and procedures, and to share information about "working the system" in order to get state benefits if possible and, if not, to calculate the costs and benefits of treatment in private clinics.

Women in IVF support groups occasionally make appeals for the continuation and extension of state investment in infertility treatments, relying on a pro-natalist discourse and "white plague" narrative, in order to legitimize their inclusion in state subsidies. Serbian law regulates assisted reproduction as a procedure available only to heterosexual couples, which is regarded by women undergoing IVF, and by the general public, as unproblematic. It has often been argued that the normalization of reproductive technologies occurs primarily by interpreting them as "appropriate ways of building a family" (Thompson 2005: 141), that is, a "natural" heterosexual nuclear family. IVF treatment can thus be represented as more worthy of social support, than some other medical interventions. Some comments on IVF forums that are critical of recent government decisions to provide state benefits to persons undergoing sex-change surgeries in Serbia rely on such a strategy of normalization. However, despite the celebratory attitude of IVF forum messages towards motherhood, there are also discussions in which women question the naturalness of the mothering instinct and readiness for motherhood. This indicates that women rely on pro-natalist discourse opportunistically, without fully identifying with compulsory motherhood, or the "taken-for-granted belief that all

5 Discussion topics concerning IVF can be found at the address: www.ringeraja.rs/forum/Zatrudnjivanje/forumid_202/tt.htm.

women aspire to having children as part of deep biological programming" (Hertz 2006: 4).

The expertise of women in support groups around IVF treatment is more conformist in regard to medical discourse in comparison to the initiative for changing childbirth practices, but this does not imply that they simply follow doctor's orders. Women undergoing IVF typically use online communication to compare doctors' advice with other women, question certain doctors' attitudes, and seek alternative means to boost their fertility, although they rarely discuss the risks of IVF or accuse doctors for mistreatment. In contrast to the women gathered around "Mother Courage", IVF support groups do not discuss Western standards of care. Women's reliance on state funds to assure them access to IVF treatment and on doctors who administer the treatment brings a certain foreclosure of the possibility to adopt a critical stance towards them. IVF users strive to achieve their goals through individual strategies, rather than through social transformation. However, the way in which women construct community and form their subjectivity around infertility treatment suggests that they actively choose between options and practice self-management.

Women's online communication is based on their own experiences of undergoing treatment, whether in state-owned hospitals or in private facilities and it makes these experiences public. However, not many narratives and discussions of women's experience of infertility and of undergoing IVF treatment can be found outside online support groups. Women are less willing to talk to outsiders or consent to be interviewed about their experience of IVF treatment, especially those who went through treatment that eventually failed, or who had some unsuccessful IVF cycles, but are still continuing treatment. Research in which interviews are conducted with women and couples dealing with IVF failure in the UK (Throsby 2004), and other similar research suggest that this is not the case in Western countries. Unwillingness to talk about IVF failure might reflect the strength of the ideology of compulsory motherhood in Serbian society, even though women might not intimately accept this ideology.[6] As Throsby argues, if treatment fails to produce a child and the achievement of reproductive goals cannot justify its undertaking, talking about this experience becomes more difficult and demands a negotiation of its naturalness and normality.

Considering the two developments I have described so far, I argue that they do not fit neatly into either side of Rose and Novas' distinction between Western and post-socialist biological citizenship. Rose and Novas' dichotomous conceptualiza-

6 This is an issue for further exploration. My experience so far is that only women who successfully finished IVF treatment, or those who are only preparing to start it, were willing to be interviewed for my research. Some of my colleagues commented that they consider it unlikely that women who underwent treatments unsuccessfully would share their experience for my research.

tion of biological citizenship does not take into account that all its elements interact and get transformed in assemblages that are context specific. Nevertheless, the framework of global assemblages is useful in their analysis because it enables us to chart mutations in citizenship which are emergent and produced by multiple determinations. Thus, the understanding of developments in Serbian reproductive biological citizenship can be achieved only through detailed investigation of a variety of conditions, global and local influences, and the dynamic positioning of actors.

In assemblages of Serbian developments, global elements interact with the social conditions and discourses of differently positioned actors. "Mother Courage", as an example of identity politics, relies on globally influential human rights discourse, although its environment is not responsive to it due to the invested professional interests and political influence of doctors. It demands rights and changes in medical practice and in social conditions of medicine, not state benefits. Unlike "Mother Courage", IVF users rely on state benefits and state-supported and medical discourses of motherhood and infertility, insofar as they are instrumental in women's reproductive strategies. However, state paternalism does not fully define their biosocial subjectivity, formed around globally present IVF technology.

Women involved in these developments form different kinds of expertise and different relationships with medical authority. Although women undergoing IVF are more conformist with regard to medical discourses, they are expected to take active responsibility for self-management as IVF patients. Since affluent women can choose private IVF clinics, there are more choices for infertility treatment than is the case for childbirth which takes place in state-owned maternity wards. However, neither development involves women who are simply passive and compliant patients. Their activity from below brings about the contestation and negotiation of the pastoral power of medical doctors, who predominantly expect patients to be compliant and do not approach them as subjects who are expected to choose their course of treatment and display entrepreneurial qualities with regard to themselves. Public stories and narratives about women's reproductive experiences that are made available through communication on the Internet play a major role in both discussed developments. Through stories and communication about their reproductive experiences, women construct plural perspectives on biology, which demonstrate how global forms interact with local discourses and conditions, and how emergent forms of biological citizenship are being assembled in multiple, complex, and contingent ways.

Post-socialist corruption in Serbian reproductive medical services

Media and citizens' online reports of corruption in state-owned reproductive medical services proliferate almost daily in Serbia. For example, the web-site of a popular daily newspaper reported in early January 2012 a story about the death

of an (arguably) over-term baby, writing that its mother was neglected for several days in a state-owned hospital in a large Serbian city (Radišić 2012). The report shows the grieving husband who recalls how doctors ignored his wife's suffering, only to inform him in a telephone call that their baby eventually died, and threatens to sue for medical malpractice. As the title of the news report states, the dead baby was left in the woman's womb for two days until it was extracted. Over 400 comments on this report were posted, in which readers blame doctors and call for their prosecution, and even demand retaliation against them, while a small minority contends that they might be not guilty for this unfortunate event. Some male commentators advise other fathers not to wait outside hospitals and hope for the best, but to bribe doctors, or to threaten them, in order to get their partners through childbirth safely. In comments to this and similar reports, some readers presume that what lead to the tragic consequences was that it was necessary to perform a Caesarean section, and that this was not done, because women did not bribe doctors in advance to perform it. It is a common opinion that Caesarean sections are acquired through corruption and connections, and we can take this opinion as an indication that citizens perceive a great presence of corruption in Serbian maternity wards.

Conceptualizations and research of corruption still present a challenge for ethnography (Torsello 2011). The most common definition of corruption, as "the abuse of a public office for private benefits and gains" (Torsello 2011: 3) presupposes the "Weberian rationality of the western bureaucratic machinery" (Torsello 2011: 3) as a norm, and assumes a clear distinction between the public and the private. Corruption in different contexts is difficult to research and grasp theoretically, because it functions in interaction with many other social practices. Therefore, it is necessary to approach corruption empirically as it emerges under specific conditions.

The "public corruption talk" (Torsello 2011) of citizens provides an opportunity for the ethnographic investigation of phenomena that are rarely directly observable, and particularly of citizens' construction of meaning around corruption. Corruption talk does not necessarily reflect or alter citizens' behaviour in practice. It allows citizens to inform themselves about the social conditions of reproductive medicine, and to reflect on the meaning of corruption, and possible responses to it. Aiming to mobilize citizens against corruption in reproductive medical services, the web-site "For Health – Together against Corruption" was started recently in cooperation between the civic initiatives "Mother Courage" and "Parent".[7] It encourages citizens to resist corruption and report corrupt doctors, and it collects and publishes citizens' experiences regarding the presence (or absence) of corruption in the medical services that they had personal contact with. Citizens

7 "For Health – Together against Corruption" web-site is at the address: http://korupcija.roditelj.org.

report diverse experiences with corruption, and some of them write about their own participation in perpetuating corruption in state reproductive medical services. A perceived lack of legal protection and of opportunities to access appropriate care makes the attitude of citizens who share stories to themselves and others non-judgemental. The need to avoid risks and reduce uncertainties in encounters with reproductive medicine leads to justifying accepting corruption as a realistic choice.

This anti-corruption web campaign, which was started by a civic initiative that demands changes in the medical management of childbirth, demonstrates how the discursive power of corruption talk can be mobilized to generate trust and form sociality, and to contribute to increase public interest for initiatives that demand rights. Online accounts about corruption, according to Torsello, have two effects. One is that they make the rules of the corruption "game" more transparent, they "establish a flow of communication about best practices" (Torsello 2011: 8), and disclose "information on the successful strategies to bribe which can commonly be acquired only through prolonged social interaction" (Torsello 2011: 19). Their second effect, which is intended by civic initiatives, is to "raise public awareness, which can be used for particular (political) goals" (Torsello 2011: 19), such as "civil society building" (Torsello 2011: 19). Making corruption talk public is strategic in this anti-corruption effort, as it draws attention to the initiative's broader demands in relation to childbirth.

Analyses of corruption in the health sector in Serbia, made by Serbian and international non-governmental organizations, agree that it is widespread, although its full extent is unknown. In one citizen's response to an online survey, corruption is described as so widespread that it has become the normal way in which the system works, and in this situation, the only important issue is "who is the best in the game" (Beogradski centar za ljudska prava 2012: 15). There are different forms of corruption in the health sector in Serbia. Petty corruption refers to "illegal payments directly to medical doctors and others in public sector to provide some services" (Center for Antiwar Action 2005: 3). Indirect payments are a widely present form of corruption in Serbia, in which patients pays for tests and examinations in connected private services, in order to earn doctors' greater attention and access to care in public services. However, "connections" represent the most important mechanism of corruption in Serbia, in which patients find intermediaries (insiders from medical institutions or other influential persons), who introduce them to health providers. Therefore, possession of money is not as important as "influence in society, represented in a patient's own capability to do something in return, or in a patient's family and friendship connections" (Center for Antiwar Action 2005: 10). What is at stake is access to appropriate medical care. International and domestic anti-corruption reports and campaigns interpret corruption as a violation of human rights: because doctors treat patients unequally, corrup-

tion leads to discrimination, and to the violation of the right to health and sometimes of the right to life. Human rights groups demand regulation from the state and the legal prosecution of corruption. In a recent online survey, 99% of respondents answered that they consider that the Serbian state does not fight corruption in health care efficiently (Beogradski centar za ljudska prava 2012: 15).

In order to explain how corruption relates to citizens' subjectivity in a post-socialist context, I will return to Petryna's analysis of Ukrainian biological citizenship (Petryna 2002: 5). She writes that bureaucrats and mediators in the Chernobyl apparatus who granted disability status to Ukrainian citizens remained "unsubordinated to any stable legal system" (Petryna 2002: 143) in their power over individuals' lives, and that they could profit from their position. At the same time, Ukrainian "economic paralysis [bred] codependencies in which compensation [was] no longer simply moral repayment; it also [served] as a stimulant to new and at times exploitative forms of accumulation" (Petryna 2002: 92). These political and economic conditions "generated new kinds of formal and informal social networks and economies that have allowed some segments of the population to survive on and benefit from politically guaranteed subsidies" (Petryna 2002: 5). *Blat* is the term denoting "the informal practice by which access to state privileges and protections could be obtained with connections or material resources" (Petryna 2002: 25). Persons with resources and knowledge about how to perform *blat* could thus gain access to paternalistic forms of social security. Petryna describes how a person who was exceptionally good in performing *blat* could "buy more diagnoses for his medical records, making his medical condition appear much more severe than it was" (Petryna 2002: 143), while other peoples' fate was sealed as they did not know how to perform it. The ability to perform *blat* can be read as a form of social capital which is mobilized in corrupt exchanges. Post-socialist economic conditions and modes of government can therefore result in an individualization of responsibility for gaining access to social security, which is "traded" in unequal exchanges and mediated through corrupt social ties.

In exchanges that mediate access to state-owned health care services in Serbia, we can locate the individualization of responsibility for one's health. Citizens' subjectivity in the context of post-socialist corruption, under conditions of legal and economic insecurity, is reminiscent of the neoliberal subjectivity of active biological citizens who relate to themselves as entrepreneurial individuals. Corruptive ties provide access to those who are "affiliated", as Rose would say, while they prevent those who are marginalized from access to health care services, and corrupt exchanges result in the accumulation and redistribution of wealth and citizens' health outcomes. If responsibility for gaining access to health care and for risks and benefits of medical procedures is individualized, it can be considered prudent to calculate corruption costs against reproductive risks. Serbian citizens who report their experiences with corruption and discuss it online, invest an effort to

gain knowledge and inform themselves about the risks of medical procedures and about the social conditions of health. In the light of the information circulated in public corruption talk, pregnant women might decide that it is prudent to invest in corrupt ties, expecting them to pay off by avoiding complications of vaginal delivery which are common in Serbian maternity wards through prearranged Caesarean sections. Corrupt markets thus have a "rationality" of their own, embedded in the interplay of the conditions of the post-socialist context, just as markets regulated by the formal and transparent rules of exchange are context-specific. This specific form of market exchanges and accumulation forms the context in which Serbian citizens relate to themselves as neoliberal subjects, and find ways to manage the risks of their reproductive biology.

Conclusion

My discussion of developments in Serbian reproductive biological citizenship has provided some insights into the ways in which its specific projects are assembled in the interaction of globally present forms with local conditions, various actors and discourses. Emergent forms of biological citizenship are produced by multiple determinations: by local histories, and cultural and social conditions, but also by the international context and global forms. None of their elements is left untransformed, thus we can only encounter them as they are assembled with other elements and conditions, and as they emerge and are constructed by biological citizens.

Discussing Serbian developments, I have claimed that identity politics around childbirth practices relies on international human rights discourses, and on the conception of citizens as subjects of experience which is publicly narrated in order to make claims for rights. However, these globally influential elements are transformed and given meaning by women as they position themselves within Serbian context. I have also claimed that women undergoing IVF form subjectivity around the global forms of biotechnology of assisted reproduction and in the context of paternalistic state measures, not as mere patients, but as persons who actively manage their infertility. Discussing citizens' public corruption talk, I pointed to economic and social conditions in which responsibility for managing health risks is individualized and in which post-socialist corruption emerges as a specific form of market relations, constructed with and through social ties. I considered the role of public talk and Internet communication in all of these developments, both as an enabling factor, and as a global form which is used and constructed according to the Serbian situation and the conceptions of Serbian biological citizens.

Anthropology aims to engage with practices in their complexity, to contextualize and deconstruct preconceived notions and question conditions of their existence. In order to analyse the ways in which biological citizenship is being assem-

bled, we need to deconstruct the dichotomy between the West and post-socialism which could hinder both research and conceptual work. Nevertheless, the conceptualization of biological citizenship as a global assemblage can be useful in comparative anthropological studies. New research of emergent territorializations of biological citizenship in different contexts promises to bring more nuanced perspectives on the notions and phenomena discussed in this paper and to lead to new conceptualizations.

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The current issue of *Sociologický časopis / Czech Sociological Review* 3/2013

Sociologický časopis/Czech Sociological Review (ISSN 0038-0288) is published bimonthly (4 issues in Czech, 2 issues in English) by the Institute of Sociology, Academy of Sciences of the Czech Republic.

Orders: Czech Sociological Review, Institute of Sociology, Academy of Sciences of the Czech Republic, Jilská 1, 110 00 Praha 1, Czech Republic, e-mail: sreview@soc.cas.cz, tel. (+420) 222 221 761, 210 310 217-218, fax 222 220 143.

One issue costs 4.5 € or 5 $

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